MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Monday, November 13, 2006
10:00 AM
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services met on Monday, November 13, 2006, at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Janet Cowell, Vernon Malone, and William Purcell and Representatives Martha Alexander, Beverly Earle, Bob England, Carolyn Justice, Edd Nye, and Fred Steen. Advisory members, Senator Larry Shaw and Representatives Jean Farmer-Butterfield and Earline Parmon were present.

Kory Goldsmith, Ben Popkin, Shawn Parker, Andrea Russo, Natalie Towns and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order, welcoming members and guests. She said that there had been several requests for time to be allotted for public comments. She was hopeful that a block of time would be available for comments for the December or January meeting. Representative Insko asked for a motion to approve the minutes from the October 4, 2006 meeting. Senator Nesbitt made the motion and the minutes were approved.

Regarding the October meeting, Senator Nesbitt noted that the consultant suggested that the hospitals needed to be downsized, but Senator Purcell commented that the General Assembly had just approved the construction of two new hospitals. He said that the recommendation did not come from the LOC, and that every recommendation made and funded was needed, and if in the future advice is needed regarding the hospitals the committee would make a recommendation.

Leza Wainwright, Deputy Director of the Division of MHDDSAS, addressed the committee on the revised cost model for payment of Local Management Entity (LMEs) functions. She said that in 2003, a consultant was hired to develop a cost model to predict the cost of LME functions. On July 1, 2004, the Division implemented the first cost model for LME functions as LMEs moved from being providers of services to being managers of services. A special provision this year in Senate Bill 1741, called on the Department of Health and Human Services to revise the cost model and present the revised model to the LOC. She said that the Department had consulted with the LMEs and in general agreed that the new model better captures what needs to be paid to the LMEs in respect of their management of service delivery for mh/dd/sa service needs.

Ms. Wainwright began by explaining the starting points for developing the new cost model. (See Attachment No. 2) She said that it was first determined exactly what functions the LMEs were to perform and defined what the State was willing to pay for and what the State would not pay for since the State pays 100% for administrative functions. It was determined that in the LME cost model the State would pay for the basic State employee benefit package. Also, the cost model does not include any costs associated with being a service provider and a reasonable basis was set for administrative salaries. Ms. Wainwright then reviewed the key functions of the LME which include: Governance; Business Management and Claims Payments; IT; Provider Relations; Screening, Triage and Referral; Service Management, Care Coordination, Community Collaboration; Customer Service; and Quality Management. In each of the functions, Ms. Wainwright explained what the State would pay for and what the State would not cover.

Ms. Wainwright said that once the LMEs and the Department agreed on the key functions, they updated the original model. Salaries were increased 7.5% which corresponds with the increase received by State employees over that same period of time. An increase for the maximum salary the State will participate in for a non-physician was set at $165,150 based on 90% of the federal maximum block grant of $183,000. Due to downsizing of the LMEs, fringe benefits were adjusted and adjustments were made to the total populations based on projections for each LME as of July 1, 2007. She said the cost model drives off the total size of the catchment area to be served. Based on national and North Carolina prevalence data, it can be assumed that 6.6% of the population will have a substance abuse issue. Using a catchment area of 200,000 with 6.6% having substance abuse issues, you can predict how many substance abusers should be in a catchment area and how many can be expected to request service through the public system.

Ms. Wainwright then gave an example excel model which was not available as a handout. Using a hypothetical LME with a population of 200,000 based on North Carolina demographic data, you could expect there to be 151,672 adults or older adults and 48,000 children. Based on national and North Carolina prevalence data, it is assumed that 16.2% of the population has some kind of MHDDSA issue except for the target population. In the target population those with severe mental illness, severe and persistent mental illness, a substance abuse issue, or a developmental disability, would equal 13.3 % of adults in that catchment area which would mean that there are 20,157 people in the hypothetical area that would meet the target population definition. Another 24,500 people would have a MHSA issue that would not fall under the target population, and 107,000 adults who do not have a MHDDSA issue at all. The model also indicates the number of people who might seek services through the public system because they are Medicaid eligible or indigent. Approximately 48% meeting the target population will seek service through the public sector, and 6% not meeting the target population but Medicaid eligible, would also receive services in the public sector. The model also projects that 23.8% of children should have a moderate to severe impairment, and 10.3% would have a mild emotional disturbance which would indicate that in this hypothetical catchment area there would be 11,502 children in the target population, slightly less than 5,000 not meeting the target population, and 32,000 without a diagnosable condition. She said that in any given year, this hypothetical LME would be responsible for managing the

services for 17,339 people. Of those, 15,196 are in the target population, 2,100 are in the non-target population – primarily Medicaid eligible. Ms. Wainwright said that a report would be published this week with data from each LME regarding the actual number of persons being served by disability which could then be compared with the prevalence estimates. It will not include services paid for by any kind of private insurance, Medicare, or county funds. Not all of the Medicaid services necessarily went to target population individuals, but it is the best comparison data available. Ms. Wainwright was asked how this cost model compared to the first cost model. She answered that there was a slight increase over what LMEs are being paid in this current fiscal year. The State dollar participation may be less since the areas of increased funding such as care coordination and provider relations are Medicaid participant areas.

Ms. Wainwright then gave the preliminary report on the Funding Allocation Study. (See Attachment No. 3) She said that the focus of the cost model was to see that service dollars were equability distribute across the State fairly. The model will be able to add or delete variables for funding considerations; have the ability to look at finance data at the county and LME level; and be able to change or mix counties and LMEs as mergers occur. She explained that the finance model would not estimate the total cost of providing services but would provide an objective basis for estimating how the cost of services could be financed through the major funding streams. The cost model will estimate the total cost of services in the Long Range Plan Gap Analysis project. She then gave an overview of all the variables of the $1.7 billion community service budget. Ms. Wainwright was asked to provide a breakdown regarding the combined amount of funds that are State and Federal Block Grant. She then pointed out potential funding sources and explained how the model would work. The committee expressed concern that looking at the property tax rate was an inaccurate way to look at the ability to pay. A more accurate way would be to look at the per capita income, the poverty level, and the ability to pay for the cost of living.

Ms. Wainwright said that Medicaid funding would be considered the primary funding source, with County General Funds second, and the final source would be Division funds, State appropriations, and federal grant funds. In closing, Ms. Wainwright said that the consultants would present the Finance cost model to the LOC at the December meeting. She said that the Division and consultants would work with the NC Association of County Commissioners and the NC Council of Community Programs on recommendations related to the finance model, and assuming the LOC and the General Assembly approve the model, implementation would be July 1, 2007.

After lunch, Representative Insko asked the audience for comments. Mary Short told the LOC that November is National Family Caregivers Month. She expressed frustration with a technical amendment to the State Plan that has been submitted to CMS. The amendment would restrict family members who provide personal services to CAP-MR/DD recipients to no more than 40 hours per week of payment for those services. It would also prohibit a family member who is a legal guardian from being paid for providing services. She expressed concern that the amendment treated family members of CAP-MR/DD waiver recipients differently than other family members of Medicaid

recipients. She said that Value Options had implemented the amendment even though CMS had not approved the amendment. Tara Larson from the Division of Medical Assistance said that she had contacted Value Options and told them not to implement the amendment.

Next, Patricia Amend, Director of Policy Planning and Technology with the North Carolina Housing Finance Agency and Julia Bick, Housing Coordinator with the Department of Health and Human Services, addressed the Housing 400 Initiative. (See Attachment No. 4) Since July, five community meetings across the State were held to gather input from developers, persons with disabilities, advocates, and service providers to see how they would like to see the Initiative 400 created. Input from the meetings was used to make decisions on how to best distribute the funds, utilizing existing staff and programs. The General Assembly budgeted $10.9 million non-recurring capital funds and $1.2 million recurring operating subsidy. The Housing 400 Initiative will be delivered through three programs; the Supportive Housing Development Program 400 (SHDP400) and the Preservation Loan Program 400 (PLP400) will deliver both capital and operating subsidy, and the Housing Credit Program will utilize the operating subsidy through the Key Program. All three of the programs will leverage other funds to help create 400 housing units for persons with disabilities. The new units could be built in 18-24 months. The PLP400 applications are due by December 8, 2006, and the SHDP400 applications are due by February 28, 2007.

Flo Stein, Chief, Community Policy Program for the Division of MHDDSAS, offered an in-depth description of Substance Abuse Services. (See Attachment No. 5) She reviewed the principles of reform developed to discuss the ideal substance abuse system. She said that the system should be participant driven utilizing the Person Centered Plan. This puts the consumer in control on some of the services available to them. The care should be customized to meet the consumers' needs. North Carolina is least effective in Access which is a key element of an effective system. She said that the system should be prevention focused, and that individuals should be screened for risk factors associated with the onset of substance use disorders and offered recommended evidence based preventive intervention. In the past, consumers have been held responsible for their outcomes. Accountability is an important part of recovery, but that accountability has now shifted to the practitioner.

When questioned about funding of substance abuse services, Ms. Stein replied that there is not adequate money or enough providers. She said that the federal government pays 87% of all substance abuse services in the United States; the next highest payer is the State; and private insurance pays 7% of all the treatment in America. She also emphasized the importance of partnerships within the community for an effective delivery system. She gave the example of a working partnership between DHHS, the Department of Corrections, and the Administrative Office of the Courts. She said that the structure was in place, we have service definitions, and we know what needs to be done, but do not have the services offered across the State or providers or the money available to implement the continuum. Ms. Wainwright added that Trust Fund dollars had been set aside to address substance abuse needs such as start-up funding for potential providers.

Kory Goldsmith from the Research Division offered a follow-up to the September meeting. She referenced members to a chart summarizing information on LMEs sliding fee scale. (See Attachment No. 6) Ms. Wainwright offered an explanation of the chart and was asked to further clarify the percentage charged to low income families. Ms. Goldsmith added that according to Statutes, an individual can not be denied services based on an inability to pay.

There being no further business, the meeting adjourned at 3:05 PM.

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Senator Martin Nesbitt, Co-Chair	Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant